PATIENT REFERRAL FORM

Fax: 318-212-7333 | Email: SpsReferrals@wkhs.com

REFERRING TO: ☐ Dr. John Noles ☐ Dr. David Hirsch ☐ Dr. Nancy Germany ☐ First Available

PLEASE INCLUDE: ☐ Imaging ☐ Last 3 Office Notes ☐ Physical Therapy Notes ☐ Demographics/Insurance

REFERRING PROVIDER INFORMATION

Date Submitted: _____ Referring Provider: _____ Office Contact: _____

Office Contact:_____ Phone: _____ Fax: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Phone: _____ Insurance:_____

CLINICAL / REFERRAL INFORMATION

Chief Complaint: _____

Diagnosis/Reason for Referral: _____

Previous Pain Management? ☐ Yes ☐ No ***Previous Provider:*** _____

Accident Related? ☐ Yes ☐ No Liability Claim? ☐ Yes ☐ No Workers' Comp? ☐ Yes ☐ No Attorney? ☐ Yes ☐ No

Implanted Pain Pump or Spinal Cord Stimulator? ☐ Yes ☐ No

Patient on Anticoagulation? ☐ Yes ☐ No If yes: Medication Name: _____

Anticoagulation Prescribing MD Name/Number: _____

REFERRAL TYPE REQUESTED

☐ Consult & Treat ☐ Procedure Only ☐ SCS ☐ MILD ☐ Intracept

PROCEDURE REQUESTED

DISORDERS OF THE SPINE

☐ **Bilateral** ☐ **Right** ☐ **Left**

☐ Transforaminal Epidural Steroid Injection: ☐ Lumbar ☐ Sacral ☐ Thoracic ***Level(s):*** _____

☐ Interlaminar Epidural Steroid Injection: ☐ Cervical ☐ Lumbar ☐ Caudal ☐ Thoracic ***Level(s):*** _____

☐ Medial Branch Block ± RFA: ☐ Cervical ☐ Lumbosacral ☐ Thoracic ***Level(s):*** _____

☐ Radio Frequency: ☐ Cervical ☐ Lumbosacral ☐ Thoracic ***Level(s):*** _____

☐ Therapeutic Facet: ☐ Cervical ☐ Lumbosacral ☐ Thoracic ***Level(s):*** _____ (limited coverage)

MUSCULOSKELETAL ULTRASOUND

☐ **Bilateral** ☐ **Right** ☐ **Left**

☐ Greater Trochanter ☐ Knee ☐ Subdeltoid Bursa ☐ Glenohumeral Joint ☐ Elbow (Lateral Epicondyle)

☐ Carpal Tunnel ☐ Other: _____

SYMPATHETIC BLOCKS

☐ **Bilateral** ☐ **Right** ☐ **Left**

☐ Lumbar Sympathetic Block ☐ Stellate Ganglion Block

CANCER PAIN AND SPASTICITY MANAGEMENT

☐ Celiac Plexus Block ☐ Neurolytic ☐ Diagnostic

FLUOROSCOPICALLY GUIDED LARGE JOINT INJECTIONS

☐ **Bilateral** ☐ **Right** ☐ **Left**

☐ Intra-articular Hip ☐ Sacroiliac Joint Injection - Diagnostic ☐ Sacroiliac Joint Injection - Therapeutic

☐ Sacroiliac Joint RFA ☐ Other: _____

All referrals and supporting documentation must be reviewed and accepted by our providers.
Once accepted, we will contact the patient within 48 hours.